Safety Culture

Professionalism: A Necessary Ingredient in a Culture of Safety

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Professionalism is the conduct, aims or qualities that define a profession or a professional person.[1] Both the nursing and medical professions are characterized by the continuing pursuit of knowledge, a sense of responsibility for human concerns, preparation through higher education, peer accountability, autonomy, and altruism. In the medical field, there is no dispute that professionalism is a sound idea, but the behavior of all health care professionals does not always conform to these ideals.[2] Unfortunately, health care has a history of tolerating and not addressing intimidating and disruptive behaviors. This lack of professionalism is critical because intimidating behaviors have been shown to foster medical errors and adverse events and decrease patient satisfaction.[3] In July 2008 The Joint Commission issued a *Sentinel Event Alert* that described Leadership Standard L.D.03.01.01, "Leaders create and maintain a culture of safety and quality throughout the hospital," and the two elements of performance (EPs) that addressed disruptive and inappropriate behaviors, as follows:

- EP 4. Leaders develop a code of conduct that defines acceptable, disruptive, and inappropriate behaviors.
- EP 5. Leaders create and implement a process for managing disruptive and inappropriate behaviors.[4,5]

The Leadership standard has focused needed attention on professionalism in health care and the importance of creating effective means to address behavior that interferes with the provision of high-quality care. By not having clear policies about professionalism, hospitals and other health care organizations allow unacceptable behaviors and create unsafe situations.

Industries with a safety culture are characterized by communications founded on mutual trust, shared perceptions of the importance of safety, and confidence in the efficacy of preventive measures.[6] In health care, a strong commitment to respect by each coworker can optimize teamwork and communication, which can lead to excellence in patient satisfaction and a decrease in adverse events.[3,7–9] A safety culture cannot exist in health care unless providers exhibit the highest levels of respect, integrity,

Article-at-a-Glance

Background: A safety culture requires the highest levels of professionalism. A Code of Professionalism was created in an obstetrics service line as a mechanism to address unprofessional behavior. In this initiative, a multidisciplinary Code of Professionalism was established, with the support of leadership and the employee and nursing unions, to help create a safety culture.

Methods: In 2005 the Code of Professionalism was introduced to physicians, nurses, and support staff. The U.S. Agency for Healthcare Research and Quality (AHRQ) Patient Safety Culture Survey was used, along with a portion of the Institute for Safe Medication Practices (ISMP) Survey on Workplace Intimidation to measure changes in the safety culture. Data were collected in 2005, 2008, and 2011.

Results: One hundred thirty-four reports were made to the committee on professionalism between February 2005 and December 2010. Some 96 (72%) of the reports were submitted by nurses, with physicians accounting for 13%. Seventy-five of the reports (56%) were about unprofessional behavior by physicians and 46 (34%) were about unprofessional nursing behavior. On the AHRQ Patient Safety Culture Survey, statistically significant improvement was shown in the Teamwork Within Units dimension, from 2005 to 2008; the Management Support dimension, from 2005 to 2008; the Organizational Learning dimension, from 2005 to 2008 and also from 2008 to 2011; and the Frequency of Events Reported dimension, from 2008 to 2011.

Discussion: Implementing a multidisciplinary Code of Professionalism can improve the safety culture in a hospital. When leadership sets clear standards and holds physicians and staff to the same standard, improvements in an organization's safety culture can serve as the foundation for the delivery of safer care.

compassion, and excellence. In other words, a safety culture requires the highest levels of professionalism.[10]

In a safety culture, leadership is clear about what is acceptable and unacceptable behavior; there is accountability. A no-blame culture is undesirable because unsafe, egregious acts cannot be tolerated and require serious consequences. In a safety culture, staff not only are encouraged to report errors and unacceptable behaviors but actually do so. A safety culture built on trust is dependent on the sharing of information and data between workers and managers.[11] Therefore, measurement is a critical component to creating and improving the safety culture. Clinical outcomes are often measured and reported in medicine, while the measurement of culture is a relatively new development in health care. Various tools to assess a safety culture have been used and validated, including the Patient Safety Culture Survey developed by the U.S. Agency for Healthcare Research and Quality (AHRQ)[12] and the Institute for Safe Medication Practices (ISMP) Survey on Workplace Intimidation.[13] These surveys enable an organization to have an objective measure of its culture and to identify any areas of the culture or environment in need of improvement.

We aimed to improve the safety culture of the obstetrics service through the implementation of a Code of Professionalism. In early 2002 the institution had a widely publicized adverse event,[14] after which small-group sessions were conducted with staff across the institution to understand barriers to providing safe care. Staff members (physicians, nurses, midwives, business associates, support associates, technicians) were asked, "What gets in the way of you providing excellent, safe care every hour of every shift of every day?" Qualitative data indicated there were significant issues of professionalism in obstetrics, such as verbal abuse, not answering pages, and rudeness, similar to what is reported in the literature.[2–4] The obstetrics staff indicated that these problems with behavior and overall professionalism interfered with providing excellent care. In addition, leadership was increasingly concerned about the financial implications of the liability climate in obstetrics. In this article, we describe a Code of Professionalism implemented on an obstetrics service to improve quality and safety.

Methods

Setting

The Mount Sinai Medical Center (New York City) is a 1,171-bed acute-care tertiary academic facility, with approximately 6,000 deliveries per year. The obstetrics service includes approximately 150 nurses, 125 physicians (attendings and housestaff), 10 midwives, and more than 50 support staff.

The chairman of obstetrics/gynecology (OB/GYN)—a physician—and the director of maternal child health*—a nurse—were enthusiastic partners who understood the importance of united, multidisciplinary leadership. They also realized that any important obstetric patient safety initiatives, such as shoulder dystocia drills, team training, and use of critical language, and quality improvement (QI) activities would not take hold unless a fair, just culture was established across the various disciplines on the clinical service.

Code of Professionalism and the Committee

The obstetrics clinical leadership (chair of OB/GYN and director of maternal child health), together with QI leadership from the hospital (executive vice-president for excellence in patient care and the director of the Joseph F. Cullman, Jr. Institute for Patient Care, which promotes caring and communication between caregivers and patients) conceptualized a Code of Professionalism as a direct outgrowth of the sessions in which staff indicated that professionalism and behavioral issues existed. The Code of Professionalism was brought to and approved by employee and nursing union leadership in early 2005 and was introduced in the obstetrics service at the Mount Sinai Medical Center in 2005. The Code of Professionalism consists of the statement and shared values, as shown in Figure 1 (page 449), and a mechanism for reporting/surveillance, intervention and feedback.

Violations of the Code of Professionalism can be reported by staff through the intranet or by telephone or in-person reporting. The Code of Professionalism committee—which consists of the nursing director and chair of OB/GYN, along with two leaders in the institution who are not in the direct reporting line of anyone on the clinical service (the vice chair for clinical affairs in pediatrics and the director of the Cullman Institute)—receives reports from all levels and disciplines of staff. Any report that requires disciplinary action, as defined by hospital policy, is referred to the appropriate body for follow-up. Many of the incidents for which the committee intervenes and provides conflict resolution would previously have gone unmentioned, deemed unworthy of a report. The committee meets on an ad hoc basis, typically once a quarter.

The committee follows up on all reported incidents. One committee member typically investigates the reported incident and then meets with the alleged offender. The committee reviews the incident and discusses alternate ways of handling the situation. In cases of repeat misbehavior, the meeting involves

* Now Women and Children's Services.

The Code of Professionalism

Mission

To provide exemplary obstetrical and gynecologic services consistently to all patients and families in a safe and collaborative environment

Vision

To become a model of world-class excellence by providing the highest quality, most comprehensive obstetrical and gynecologic services to patients and families and by promoting and sustaining an interdisciplinary, collaborative, and trusting working environment of all staff. We aim to achieve unprecedented excellence in patient safety, clinical outcomes, the experiences of patients and families, and the working environment of our caregivers.

The Code of Professionalism

We will ensure that all patient care, employee interpersonal communications, and other day to day operations are conducted with the utmost professionalism and compassion. We developed this Code of Professionalism to guide our daily interactions toward consistent excellence and to prevent conflicts and other inappropriate behaviors.

Shared Values

integrity
compassion
respect
excellence

Figure 1. *The Code of Professionalism is shown, along with the mission, vision, and shared values.*

the entire committee. If there is an issue regarding teamwork, a committee member may meet with both people involved in the specific issue. In all situations, staff is reminded that there must be no retaliation against or repercussions for a person reporting in good faith.

To implement the Code of Professionalism across the obstetrics service, educational sessions were held at various times and places to ensure that all staff were reached. The leadership presented the Code of Professionalism in sessions at both daytime and nighttime staff meetings, Grand Rounds conferences, and resident educational meetings. The sessions included a didactic portion, with background on the science of safety and the urgent need in health care for a safety culture. During the educational sessions, the staff was also given an opportunity to discuss professionalism incidents and ask questions. The mechanism for reporting inappropriate behaviors was introduced. Reporting was described as a means of improvement not as an avenue for complaints or "tattling." Staff were encouraged to report all incidents of unprofessional behavior, regardless of whether they were involved or witnesses. Visual reminder cues, such as buttons, identification (ID) tags (Figure 2, page 450), and flyers, highlighting the Code of Professionalism and ways in which to report incidents were available at the sessions and on the units.

Outcome Measures

The AHRQ Patient Safety Culture Survey, along with portions of the ISMP Survey on Workplace Intimidation, was administered to staff throughout the obstetrics clinical service to assess the safety culture and target future improvements accordingly. The AHRQ survey measures eight unit-level aspects of safety culture, two hospital-level variables, and four outcome variables.[15] The validity and reliability of the instrument have been discussed elsewhere.[16] For analytic purposes, positive responses include "Strongly Agree/Agree" or "Most of the time/Always" and for reverse-worded items, the number of "Strongly Disagree/Disagree" or "Never/Rarely" responses (disagreement) indicates a positive response. Although the Patient Safety Culture Survey measures many different dimensions related to patient safety, we focused on the dimensions that may be directly affected by the implementation of the Code of Professionalism—the dimensions of Teamwork Within Hospital Units (Teamwork within Units), Organizational Learning—Continuous Improvement (Organizational Learning), and Hospital Management Support for Patient Safety (Management Support). In addition, we chose to review the dimension of Frequency of Events Reported because of our belief that the Code of Professionalism would improve comfort with reporting events, and thereby assist with increased reporting.

Specific items from the ISMP survey, added to the end of the AHRQ survey, were included to measure disruptive and intimidating behaviors that were not sufficiently covered in the AHRQ tool. For each item in the ISMP survey, the respondent is asked, "How often have you encountered this behavior over the prior year?" The respondent can answer "Often" (> 10 times), "Sometimes" (3–10 times), "Rarely" (1–2 times), or "Never." The percentage of respondents who indicated they had never encountered the specified behavior in the question over the past year was measured.

In February 2005 and again in March 2008, a hard copy of the survey was given to all staff working on the obstetrics service. Anonymous surveys were distributed at staff meetings and at Grand Rounds.

Sample Identification Tag with Code of Professionalism

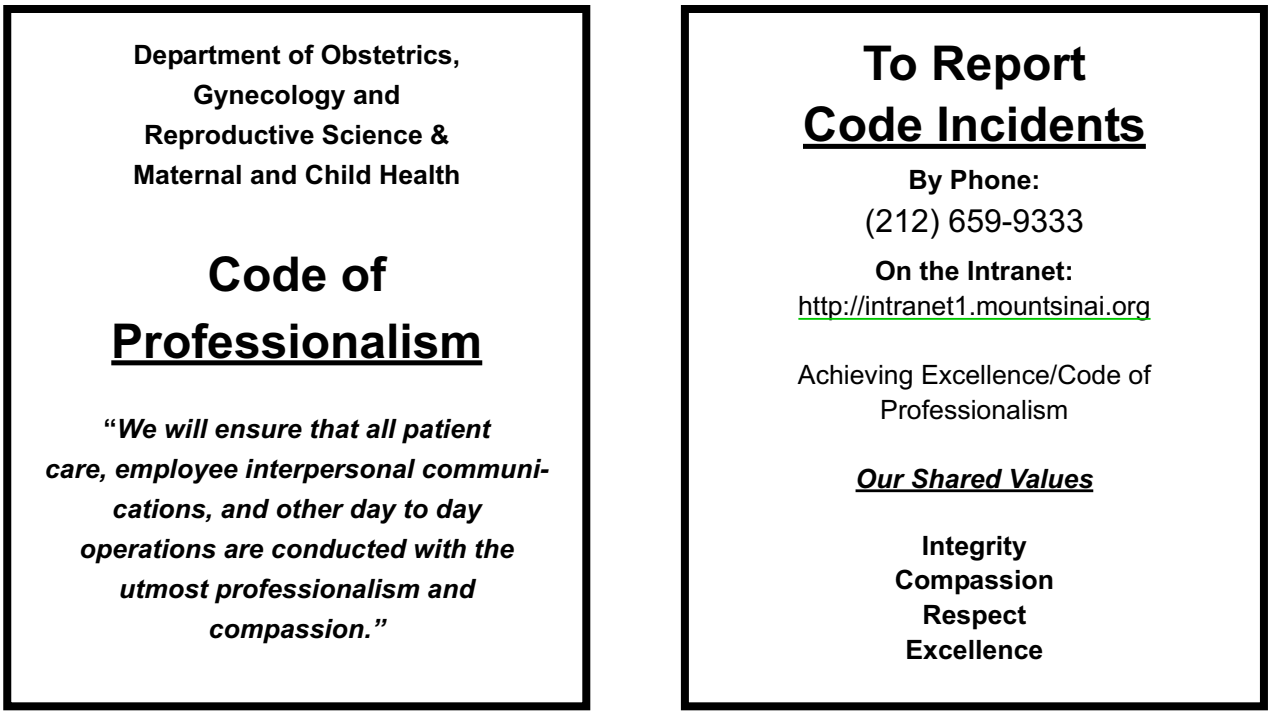


Figure 2. *The identification tag provides the Code of Professionalism, reporting information, and Shared Values.*

In February 2011 the institution used an online web-based tool for the AHRQ Patient Safety Culture Survey.[17] It was not possible to embed the ISMP survey items into the online AHRQ survey tool. Therefore, in 2011, the ISMP survey items were not administered.

Statistical Analysis

The surveys were analyzed and tabulated using WinCross 10.0 software (The Analytical Group, Inc., Scottsdale, Arizona). Statistical significance was determined with chi-square tests.

Results

Code of Professionalism Reports

One hundred thirty-four Code of Professionalism reports were submitted between February 2005 and December 2010. During 2010, 39 reports were submitted—more than double the number submitted in 2005 (15) and 2006 (14). Eighty-two reports (61%) were submitted anonymously. Most of the reports (72%) have been submitted by nurses, with physicians accounting for 13%. The type of staff making the report can usually be identified even if the report is anonymous. In 12 cases (9%), the type of staff member making the report is unknown. Seventy-five of the reports (56%) were about unprofessional behavior by physicians, and 46 (34%) were about unprofessional nursing behavior. The majority of the reports (107) were submitted by personnel involved in the incident, with 27 (20%) of the reports coming from a third party who witnessed the incidents.

Incidents are categorized into one or more of the following categories: attitudes/communication/teamwork and policy. The majority of incidents (127) involved attitudes/communication/teamwork. Of the 134 reports, 28 were related to policy issues, such as lack of standardized transfer orders and the need for an updated induction policy.

The committee took action in response to the Code of Professionalism reports in a variety of ways (Table 1, page 451). Eighty-nine (66%) of the reports were addressed through one-to-one coaching with a member of the committee. Twelve (9%) of the reports were addressed with two committee members to provide a broader discussion of the unacceptable behavior. One incident resulted in a coaching session, in which all four members of the committee met with the individual. This situation is reserved for cases of repeat offenders. The chair, as a member of the committee, is involved in most cases involving a physician.

Some 20 incidents were simultaneously reported as Code of

Table 1. Code of Professionalism Committee Actions

Committee Action	*n* (%)
One-to-one coaching with committee member	89 (66%)
Two-to-one coaching with committee member	12 (9%)
Meet with entire committee (for repeat offenders)	1 (1%)
Coincided with disciplinary process (committee relinquishes control)	20 (15%)
Resulted in discipline after committee's review of incident	5 (4%)
Referral to third party	7 (5%)

Professionalism and disciplinary issues. In such cases, the Code of Professionalism committee relinquishes control and does not participate in the disciplinary process. In 5 cases, the behavior reported was reviewed by the committee and subsequently resulted in disciplinary action. In the remaining 7 cases, the alleged offender was outside the scope of the obstetrics service, and those cases were referred to the relevant hospital department. In this situation, the relevant department follows up and reports back to the committee. (If the reported behavior does not correspond to a clearly defined behavior requiring discipline, then the course of action is determined by the individual department.)

Staff Surveys

AHRQ Patient Safety Culture Survey and ISMP Survey on Workplace Intimidation. In February 2005, 163 (52%) of the 316 Patient Safety Culture/ISMP Surveys were completed and returned. Of the respondents, one third had worked at Mount Sinai for less than 5 years; one third, 5–15 years; and the remaining one third, more than 15 years. Nursing accounted for 37% of the respondents, and physicians, including attendings and residents, accounted for 25%. (A combination of administrative staff, patient care associates, obstetrics technicians, and midwives accounted for the remaining 38%.) Some 86% of the respondents had direct contact or interaction with patients.

In March 2008 the Patient Safety Culture/ISMP Survey was distributed to 320 individuals and was completed by 234 (73%). Forty-four percent of the respondents had worked at Mount Sinai for less than 5 years. Nursing respondents constituted 48% of the responses, while physicians accounted for 21% of respondents. Ninety-four percent of respondents reported having direct contact or interaction with patients. In February 2011 the Patient Safety Culture Survey was administered online: 325 of 377 were completed, for a response rate of 86%. Almost half of the respondents were from nursing, and one third of respondents had worked at Mount Sinai for less than 5 years. Ninety-eight percent of the respondents reported having direct interaction with patients.

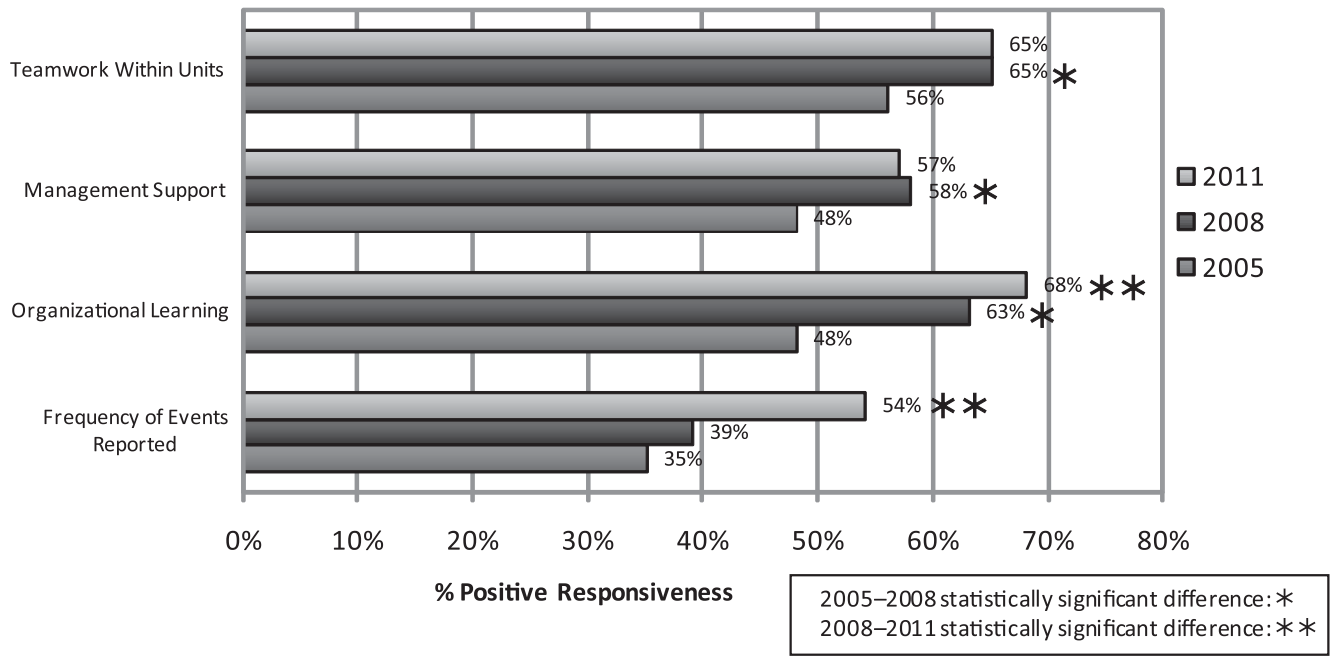
AHRQ Patient Safety Culture Survey. Figure 3 (page 452) illustrates the four dimensions of interest in 2005, 2008, and 2011. Improvements over the period of interest were shown for all of the dimensions, as follows:

- The Teamwork Within Units and the Management Support dimensions both had statistically significant improvement from 2005 to 2008 ($p < .05$)
- The Organizational Learning dimension had statistically significant improvements from 2005 to 2008 ($p < .001$), and again from 2008 to 2011 ($p < .001$).
- For the Frequency of Events Reported, the improvement from 2005 to 2008 was not statistically significant ($p = .26$), but the improvement from 2008 to 2011 was significant ($p < .05$).

In Table 2 (page 453) the specific items in each of the dimensions of interest and the corresponding percentage of positive responses in 2005, 2008, and 2011 are shown. For the Teamwork within Units dimension, all items trended positive between 2005 and 2008. Between 2008 and 2011, the items remained stable. For Management Support, responses on all items in the dimension moved in a positive direction between 2005 and 2008, although only one item, "The actions of hospital management show that patient safety is a top priority," was statistically significant ($p = .003$). The 2011 data show that the earlier gains were maintained. For the Organizational Learning dimension, all three of the items had statistically significant increases between 2005 and 2008. The item, "After we make changes to improve patient safety, we evaluate their effectiveness," improved significantly between 2008 and 2011, as well ($p < .05$). In the Frequency of Events Reported dimension, there were no changes for any of the items between 2005 and 2008. However, all three items improved between 2008 and 2011, at a statistically significant level ($p < .05$) for two of them.

ISMP Survey on Workplace Intimidation. Intimidating behaviors by physicians and others (for example, pharmacists, nurses) in the form of reluctance or refusal to answer questions, return phone calls or pages, impatience with questions, and condescending language or tone and verbal abuse are reported in Table 3 (page 453). Each item had a positive trend from 2005 to 2008, with a larger percentage of respondents reporting that the behaviors never occurred in 2008. Three items were statistically significant at $p \leq 05$: (1) "Reluctance or refusal to answer questions, return phone calls or pages by physicians/prescribers," (2) "Strong verbal abuse by physicians/prescribers," and (3) "Impatience with questions by others.

U.S. Agency for Healthcare Research and Quality Patient Safety Culture Survey: Composite Table for the Four Dimensions of Interest for 2005, 2008, and 2011



Positive Response: "Strongly Agree/Agree" or "Most of the time/Always" are positive responses for positively worded items. For reverse-worded items, the number of "Strongly Disagree/Disagree" or "Never/Rarely" responses (disagreement) indicates a positive response.

Figure 3. *Improvements during the period of interest were shown for the four dimensions of interest.*

Discussion

The results from our survey and Code of Professionalism reports illustrate how implementing a multidisciplinary Code of Professionalism with the full support of the nursing leadership, physician leadership, and the union can improve the safety culture in a hospital. The importance of nursing and medical leadership's joint setting of standards regarding conduct and aims cannot be underestimated. Leadership's role is to prioritize the creation and measurement of a safety culture to drive improvement in the progression to becoming a high-reliability organization.[18] Critical components of a safety culture are fairness and justice,[18] which depend on consistent standards regarding professionalism. In our institution, the Code of Professionalism reports often described incidents in which staff yelled at one another in public areas, sometimes with patients present. Although concerns over lack of professionalism and workplace intimidation are still evident, individuals in the obstetrics service understand that anything less than the highest levels of professionalism and patient care is not acceptable.

The Code of Professionalism was implemented to address behaviors that do not warrant outright discipline and to standardize the response to unprofessional incidents. In most health care organizations, it is such behaviors that go "under the radar" and do not rise to the level of being addressed by administration. Indifference to these unprofessional behaviors ultimately compromises patient safety, while also creating an atmosphere of distrust among staff. Vanderbilt University Medical Center describes a progressive model of professionalism, from education to accountability. It is broad in its reach, with the goal of identifying, measuring, and addressing unprofessional behaviors.[19] The policy is for all faculty and staff, although the majority of the interventions are focused on physicians and medical education. Although those efforts are commendable, they have the potential to perpetuate the silos that create the hierarchies and tensions that historically have led to unprofessional behavior in health care. The interdisciplinary nature of our initiative is both unique and critical to its success in that the Code of Professionalism displays a single standard of professional behavior for all

Table 2. U.S. Agency for Healthcare Research and Quality Patient Safety Culture: Percentage of Positive Responses, 2005, 2008, and 2011

Dimension, Item	2005	2008	2011
Teamwork Within Units			
People support one another in this unit.	63	70	74
When a lot of work needs to be done quickly, we work together as a team to get the work done.	64	75*	74
In this unit, people treat each other with respect.	50	60*	59
When one area in this unit gets really busy, others help out.	44	52	55
Management Support			
The actions of hospital management show that patient safety is a top priority.	52	67*	63
Hospital management provides a work climate that promotes patient safety.	57	65	64
Hospital management seems interested in patient safety only after an adverse event happens (reverse worded).	44	45	44
Organizational Learning			
Mistakes have led to positive changes.	41	52*	59
We are actively doing things to improve patient safety.	61	82*	81
After we make changes to improve patient safety, we evaluate their effectiveness.	42	55*	66†
Frequency of Events Reported			
When a mistake is made, but is caught and corrected before affecting the patient, how often is this reported?	32	33	52†
When a mistake is made, but has no potential to harm the patient, how often is this reported?	28	31	50†
When a mistake is made that could harm the patient, but does not, how often is the reported?	47	53	60

* 2005 vs. 2008, $p < .05$.

† 2008 vs. 2011, $p < .05$.

Table 3. Institute for Safe Medication Practices (ISMP) Survey on Workplace Intimidation: Potentially Intimidating Behaviors, 2005 and 2008

Over the past year, have you NEVER encountered. . .	2005	2008
Reluctance or refusal to answer questions, return phone calls or pages by physicians/prescribers	17.7%	20.9%
Impatience with questions by physician/prescribers	14.5%	18%
Condescending language or tone by physician/prescribers	12.1%	17.5%
Strong verbal abuse by physician/prescribers	42.2%	54.8%*
Reluctance or refusal to answer questions, return phone calls or pages by others	23.6%	35.2%*
Impatience with questions by others	20.3%	30.8%*
Condescending language or tone by others	23.3%	29.6%
Strong verbal abuse by others	61.5%	61.9%

* $p < .05$.

staff, regardless of position.

Teamwork among health care disciplines is often less than optimal. Even though nursing and medical professionals have similar aims—for example, to deliver patient-centered care—and work on the same units in hospitals and clinics, the messages regarding professionalism from leaders are separate and oftentimes distinctly different. Such differential treatment of disciplines can inherently lead to a distrust of leadership. Discrepancies in expectations regarding conduct and accountability for members of different disciplines who work on the same unit are unfair and will be perceived as such by workers. Survey responses from more than 1,500 physicians and nurses in 50 Veterans Health Administration (VHA) hospitals across the United States revealed that disruptive behavior has negative or worsening effects on stress, frustration, concentration, communication, collaboration, information transfer, and workplace relationships.[3] In another, more recent survey, 67% of the 4,530 respondents—primarily nurses or physicians at 388 hospitals in four VHA regions—

perceived disruptive behaviors to have a worsening effect on adverse events, medical errors, and patient safety.[20]

The Code of Professionalism creates a mechanism for reporting unprofessional behaviors that, as already stated, were too often previously unaddressed. Improved clarity and accountability among workers and between workers and leadership likely leads to improved communication and teamwork. For example, nurses should feel more comfortable communicating with a physician who no longer uses condescending tone or language. With the Code of Professionalism in place, an improvement in the Teamwork Within Units dimension was seen for the 2005–2008 period and sustained for the 2008–2011 period. Simulation of obstetric emergencies, standardized interdisciplinary fetal monitoring training, and team training occurred during 2009 and 2010. Those interventions likely contributed to the sustained improvement in surveys for 2011, and possibly the increase in the number of Code of Professionalism reports in 2010, as the workers gained even more clarity about professionalism and teamwork principles.

The 2005 scores on the ISMP items indicated a serious problem with intimidating behaviors in obstetrics, one that improved slowly by 2008. Although it is not possible to attribute direct cause and effect to the implementation of the Code of Professionalism and the improvements in the safety culture, we believe that it helped form a foundation for a just culture and contributed to the statistically significant improvements seen in 2008 for the following dimensions: Teamwork Within Units, Management Support, and Organizational Learning. The Frequency of Events Reported dimension had very little improvement by 2008, with any improvement occurring subsequent to that in the other dimensions. An increase in reporting might be expected to follow these improvements, rather than occurring concurrently, as frontline workers in the 2005–2008 period became more trusting of leadership and more comfortable with submitting reports. (An online reporting system for near misses and incidents, implemented in fall 2009, replaced a hybrid paper-and-online system.)

To sustain its initial implementation, the Code of Professionalism was integrated into the overall communications with staff and linked to the quality of care delivered to patients. Each time a new initiative or policy was implemented or feedback was given to the staff regarding survey results, the Code of Professionalism was reviewed with all staff and physicians. Initially, The Code of Professionalism was not set up as part of the obstetric quality infrastructure. However, with the continued improvement of our internal quality structure and developments such as Joint Commission standards regarding the process of physician credentialing[5]* the incidents became part of the quality profiles for individuals that are reported. The Code of Professionalism is consistent with, but separate from, the institutional Code of Conduct. There is recognition that the visibility of joint leadership and the process for reporting across the organization could be improved and work is underway to do so.

In addition to attention paid at the individual staff level, systemwide failures have also been identified through this mechanism of reporting. As noted in the "Results" section, specific policies were addressed and improvement projects were initiated as a result of Code of Professionalism reports (each of which pointed to individual issues with professionalism), as in the following two examples:

- One report that highlighted the inadequacies of the labor and delivery's intercom system became part of the rationale for implementing a voice recognition system enabling hands-free, voice-controlled wireless voice communication on the service.
- The patient registration system, along with the system for ensuring that prenatal records were on the unit when a patient presented for delivery, were addressed in a Six Sigma improvement project.

The specific focus of the Code of Professionalism committee is to stand firmly and consistently for professional behavior. Everyone, regardless of position, who works on the obstetrics service is expected to comply with the standards.[21] With rare exception, once an individual has been "Coded," that individual is not implicated in future Code of Professionalism reports.

With the Code of Professionalism in place, the obstetrics service has integrated best-practice guidelines, simulation of obstetric emergencies, standardized fetal monitoring training for all disciplines, and team training.

A limitation of the Code of Professionalism initiative was the lack of clarity regarding when a behavior (or repeat behaviors) should be considered for disciplinary action. For example, when a physician repeatedly engages in disrespectful communication with staff that does not clearly require disciplinary action, it is up to the discretion of the Code of Professionalism committee and the departmental chair as to when discipline is invoked. Another limitation was the fact that the initiative was restricted to only one service line. As practitioners and staff interface with other employees throughout the organization, they may run into different levels of acceptance and tolerance for unprofessional

* The standards, which call for an Ongoing Professional Performance Evaluation (OPPE), went into effect on January 1, 2008. They require a quantitative, competency-based evaluation of clinical performance that is both evidence-based and continuous. Standard MS.08.01.03: "Ongoing professional practice evaluation is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of renewal."

behavior. A final limitation is the lack of data for the ISMP component of the survey in 2011. The decision to use the AHRQ online tool impeded the ability to remeasure the ISMP items a third time. The ISMP survey uncovered previously unmeasured issues that were critical to understand in the early part of the intervention, and the impact of the Code of Professionalism on those areas cannot be known.

Summary and Conclusions

Adverse events in health care often have communication issues at the heart. The Code of Professionalism at the Mount Sinai obstetrics service is a model of multidisciplinary collaboration on the issues of communication and behavior among health care workers. Visible leadership support, from both nursing and physician arenas, is a necessary foundation for patient safety initiatives, as is the foundation of a fair and just culture. The Code of Professionalism has allowed incidents that previously might have been ignored to be brought forward to leadership for review and accountability. Spread of the Code of Professionalism to other services or even to the organization as a whole is under consideration. True advancement of the urgent safety and quality agenda for health care will take hold only when professionalism is seen as a critical building block. J

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